Public Employees Benefits Board (PEBB)

2007 Employee Enrollment/Change

- **List all eligible family members and indicate their enrollment status on this form.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.
- Attach appropriate **dependent certification** form(s) if required.

Are you making changes to an existing account? ☐ Yes ☐ No	**If yes, what type of changes:** *(Check all that apply.)* ☐ Name ☐ Address ☐ Medical plan ☐ Dental plan ☐ Adding family member ☐ Re-enrollment ☐ Waiving coverage ☐ Termination
Are you or any eligible family members enrolled in PEBB coverage under another account? ☐ Yes ☐ No	

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Address _____ Apt./unit number _____

City	State	ZIP Code	County of residence

Date of birth (mm/dd/yyyy)	Work phone number (including area code)	Home phone number (including area code)

The medical plans marked with an asterisk* in Section 4 assign a physician or clinic code to their providers and require you to choose a primary care provider. **To find the code, contact your plan or go to the Provider Directory on our Web site.**

Physician or clinic code _____

Medical Coverage	☐ Enroll	☐ Waive: date effective_____	*If waiving, see Section 6.* **Note:** If you waive coverage, medical coverage will automatically be waived for all family members.
Dental Coverage	☑ Enroll	(Dental may not be waived)	

Section 2: Spouse or Same-Sex Domestic Partner

*List your eligible spouse or same-sex domestic partner and indicate their enrollment status, even if you do not want coverage for them; they **cannot** be enrolled in any other PEBB coverage.*

Relationship to Subscriber
If adding a spouse or partner, please attach a completed *Declaration of Marriage or Same-Sex Domestic Partnership* form.

☐ Spouse: date of marriage _____

☐ Same-sex domestic partner: date criteria met _____

Social security number	Last name	First name	Middle initial	Sex ☐ M ☐ F

Address (if different from subscriber)	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	Physician or clinic code (contact plan for code)

Medical Coverage	☐ Enroll	☐ Waive: date effective_____	*If waiving, see Section 6.*
Dental Coverage	☐ Enroll	☐ Waive: date effective_____	

Terminate Medical & Dental Coverage

☐ Divorce/Dissolution of partnership: date of event _____

Please provide his/her new address_____

_____

☐ Death: date of event_____

☐ Other:_____Date effective _____

Visit our Web site at www.pebb.hca.wa.gov

Washington State Health Care Authority
Public Employees Benefits Board

HCA 50-400 (10/06)

Agency name	Agency/subagency	Ins. effective date	Hire date

Section 3: Family Member Information (such as child, grandchild, etc.)

*List all **eligible** family members and indicate their enrollment status; family members **cannot** be enrolled in any other PEBB coverage. **Use additional forms for more members.** Please attach appropriate **dependent certification** form if required.*

A **Relationship to subscriber** | ☐ Disabled? ☐ Student? (Check only if age 20 or older.) | Sex ☐ M ☐ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ☐ Enroll ☐ Waive: date effective _____

Dental Coverage ☐ Enroll ☐ Waive: date effective _____

If waiving, see Section 6.

☐ Terminate

Reason _____

Date effective _____

B **Relationship to subscriber** | ☐ Disabled? ☐ Student? (Check only if age 20 or older.) | Sex ☐ M ☐ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ☐ Enroll ☐ Waive: date effective _____

Dental Coverage ☐ Enroll ☐ Waive: date effective _____

If waiving, see Section 6.

☐ Terminate

Reason _____

Date effective _____

C **Relationship to subscriber** | ☐ Disabled? ☐ Student? (Check only if age 20 or older.) | Sex ☐ M ☐ F

Social security number | Physician or clinic code (contact your plan for code)

Last name | First name | Middle initial | Date of birth (mm/dd/yyyy)

Address (if different from subscriber) | City | State | ZIP Code

Medical Coverage ☐ Enroll ☐ Waive: date effective _____

Dental Coverage ☐ Enroll ☐ Waive: date effective _____

If waiving, see Section 6.

☐ Terminate

Reason _____

Date effective _____

Section 4: Medical Plan Selection *(Check only one.)*

- ☐ Community Health Plan Classic
- ☐ Group Health Classic
- ☐ Group Health Value
- ☐ Kaiser Permanente Classic
- ☐ Kaiser Permanente Value
- ☐ Regence Classic*
- ☐ Uniform Medical Plan

These plans require the physician or clinic code of your selected primary care provider. **Contact the plan for code or go online to www.pebb.hca.wa.gov for provider directory.*

Section 5: Dental Plan Selection *(Check only one.)*

Preferred Provider Organization

☐ Uniform Dental Plan (Group #3000)
(may receive services from any provider)

Note: Delta Dental is the parent company of Washington Dental Service (WDS). WDS administers both the Uniform Dental Plan and DeltaCare.

Managed Care Plans

☐ DeltaCare (Group #3100)
Dentist name or clinic code _____
(must receive services from *DeltaCare provider*)

☐ Regence BlueShield Columbia Dental Plan
Clinic location _____
(must receive services from *Willamette Dental Group provider*)

Section 6: Signature *(Required)*

I declare that my family members and I are eligible for the coverage requested. I authorize my employer to deduct from my earnings any premium I am required to pay for the coverage I have selected. I understand that I may be subject to dismissal and/or repayment of any claims paid by my health plan or premiums paid by my employer if I have provided false, incomplete, or misleading information, or fail to update this information in accordance with eligibility guidelines. A deposit of premium does not guarantee coverage and will be returned if I am determined by the Washington State Health Care Authority to be ineligible for coverage.

I declare that I or any family members who have chosen to waive medical/dental coverage, as indicated above, currently have other continuous, comprehensive group medical/dental coverage. I understand that proof of continuous, comprehensive group medical/dental coverage will be required to re-enroll family members in a PEBB plan outside of an open enrollment period. Application for re-enrollment must be made within 60 days of losing other coverage. This form supercedes all forms and submissions I have previously made for PEBB coverage.

Washington State law may require disclosure of any information I submit as public record. The Health Care Authority's Privacy Notice is available upon request by calling 360-923-2822 or online at www.hca.wa.gov.

Subscriber's signature _____ **Date** _____

Please sign and date this form. Return completed form to your personnel, payroll, or benefits office.